North Carolina Department of Health and Human Services
Division of Public Health

INFORMED PATIENT CONSENT TO DO HIV TESTING AND RECORD TEST RESULTS

PLEASE READ CAREFULLY

I, _____,
(Print your name)

have read (or have had read to me) and received a copy of *"HIV TESTING and COUNSELING, AM I INFECTED?"*

If I choose not to be tested for HIV infection, I understand that services will still be provided.

My questions about the tests have been answered to my satisfaction.

☐ **YES, I DO** agree to be tested confidentially and understand that my test results will be recorded in my medical record. Information collected may be used to evaluate the HIV counseling and testing program. All program evaluations will maintain confidentiality.

☐ **NO, I DO NOT** agree to be tested confidentially at this time for HIV infection.

_____ _____
Date Patient's Signature/Guardian

DHHS 3956 (Revised 8/02)
HIV/STD Prevention and Care Branch (Review 8/05)

INSTRUCTIONS TO STAFF

Purpose:

To provide a system for local health departments to document that informed consent has been obtained from clients to administer the HIV tests and to record test results in medical records.

Preparation:

Give brochure, *"HIV TESTING AND COUNSELING, AM I INFECTED?"* and have clients to: 1) read the consent form (or if indicated, read to clients), 2) print their name in the space available, 3) check the box that indicates their decision to test or not to test, and 4) sign and date the form.

Distribution:

Retain in client's medical record.

Disposition:

This form may be destroyed in accordance with Standard 5 – Patient Clinical Records of the *Records Disposition Schedule* published by the North Carolina Division of Archives and History.

Reorder:

Additional forms may be ordered from:

NC Department of Health and Human Services
Division of Public Health
HIV/STD Prevention and Care Branch
1902 Mail Service Center
Raleigh, North Carolina 27699-1902
Telephone: 919-733-7301 Fax: 919-733-1020